VENTURA COUNTY HEALTH CARE PLAN

Market Events Criteria

Target Medication	Market Events Criteria	Approval Duration	TAC Review Date
Advair Diskus (brand)	Approve if the patient has tried one of the following: fluticasone-salmeterol inhalation powder (generic to Advair Diskus), Wixela Inhub **[documentation required]**.	1 year	4/19/2024 Effective for 7/8/2024
Alcortin A (hydrocortisone 2%/iodoquinol 1%/aloe 1% gel)	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five single-entity corticosteroid topical agents AND one prescription topical anti-infective agent. Note: Examples of topical corticosteroids include: hydrocortisone cream/lotion/ointment [multiple brand and generic products], betamethasone cream/ointment/lotion [Diprolene, generics], clobetasol cream/gel/lotion [Temovate, Clobex, generics], fluocinolone ointment/cream [Synalar, generics], fluocinonide cream/ointment/gel [generics], mometasone cream/lotion/ointment [Elocon, generics], triamcinolone cream/ointment/lotion [generics]. Note: Examples of prescription topical anti-infectives include: mupirocin 2% cream [Bactroban, generics], mupirocin 2% ointment [Bactroban, generics], Centany ointment, Centany AT ointment, Altabax ointment).	1 year	2/14/2024
Amrix ER (cyclobenzaprine ER) 15 mg and 30 mg capsules, generics	Approve if the patient has tried and cannot take cyclobenzaprine 5 mg or 10 mg tablets (generics), if formulary. If cyclobenzaprine 5 mg or 10 mg tablets (generics) are non-formulary, approve.	1 year	2/14/2024
chlorzoxazone 250mg (generics)	**1.** Direct to the 500 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the chlorzoxazone 500 mg tablets. Note: If the 500 mg tablets are not currently available, approve a 1-time override.	1 year	2/14/2024
clemastine 0.5 mg/0.5mL syrup (generics)	**1.** Approve if the patient has tried five oral antihistamines (e.g., clemastine tablets, diphenhydramine, chlorpheniramine, carbinoxamine, hydroxyzine, cetirizine). **2.** If the patient is unable to swallow or has difficulty swallowing tablets, approve if the patient has tried at least two of the following: carbinoxamine syrup, diphenhydramine solution, or hydroxyzine solution or syrup.	1 year	2/14/2024
Consensi (amlodipine/celecoxib) tablets Available as a brand product in the following strengths: amlodipine 2.5 mg-celecoxib 200 mg amlodipine 5 mg-celecoxib 200 mg amlodipine 10 mg-celecoxib 200 mg	Market Events does not cover this medication.	N/A	2/14/2024
dexchlorpheniramine 2 mg/5mL oral solution (generics)	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of the following products: loratadine, fexofenadine or cetirizine AND the patient has also tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with chlorpheniramine. **NOTE:** Prescription or over-the-counter (OTC) products would count toward meeting the requirement.	1 year	2/14/2024
Dolobid (diflunisal)	Approve if the patient has tried five prescription-strength oral NSAIDs **[documentation required]**. Note: For example: nabumetone (generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. Note: Five unique NSAIDs should be tried.	1 year	2/12/2025 Effective for 4/1/2025
Endari 5 gram powder packet	**1.** Approve if the patient has tried or is currently receiving one hydroxyurea product (hydroxyurea, Droxia, Siklos). If none are formulary, approve. **2.** If, according to the prescriber, the patient is not a candidate for a hydroxyurea product (e.g., a patient who is planning to become pregnant; a pregnant patient; or a patient with an immunosuppressive condition [such as cancer]), approve. Note: If the patient has already tried (or is currently taking) a hydroxyurea product, they would not be expected to try another hydroxyurea agent. For example, if the patient has already tried Droxia, the patient would not be required to try Siklos (even if Siklos is the only formulary agent).	1 year	2/14/2024
fenofibrate 120 mg tablets (generics)	**1.** Direct to other fenofibrate products. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use other fenofibrate products. Note: Examples of other fenofibrate products include fenofibrate (Tricor, Lofibra, generics), fenofibric acid (Trilipix, Fibricor, generics).	1 year	2/14/2024
Fexmid (cyclobenzaprine) 7.5 mg tablets, generics	**1.** Direct to cyclobenzaprine 5 mg or 10 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the cyclobenzaprine 5 mg or 10 mg tablets.	1 year	2/14/2024
Glycopyrrolate 1.5 mg tablets	Approve if the patient has tried glycopyrrolate 1 or 2 mg tablets, if formulary. If glycopyrrolate 1 or 2 mg tablets are non-formulary, approve.	1 year	2/14/2024

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Gocovri (amantadine) ER capsules	Approve if the patient has tried one product from the following list: amantadine capsules, amantadine tablets, or amantadine oral solution AND meets one of the following (A or B): A. Patient derived benefit from immediate-release amantadine, but had intolerable adverse events, as determined by the prescriber; OR B. Patient could not achieve a high enough dosage to gain adequate benefit, as determined by the prescriber.	1 year	2/14/2024
Indocin (indomethacin) 50 mg Suppository; Indomethacin 100 mg Suppository	Market Events does not cover this medication.	N/A	2/14/2024
Indocin (indomethacin) oral suspension	Approve if the patient has tried one of ibuprofen suspension (e.g., Motrin, generics) or naproxen suspension (e.g., Naprosyn, generics). If neither are formulary, approve. **NOTE:** Over-the-counter ibuprofen suspension would count as an alternative.	1 year	2/14/2024
ketoprofen 25 mg capsule	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	2/14/2024
lactulose 10 gram packet (generic)	Approve if the patient has tried lactulose solution for oral administration. If lactulose solution for oral administration is non-formulary, approve. **NOTE:** A trial of the requested agent would NOT count toward meeting this requirement.	1 year	2/14/2024
Latuda tablets (brand)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	2/14/2024
Levorphanol 2 mg and 3 mg tablets	Approve if the patient has tried three medications (each from a different group) of the following: a morphine-containing product, a hydrocodone-containing product, a hydromorphone-containing product, an oxycodone-containing product, an oxymorphone-containing product, a fentanyl-containing product, a methadone-containing product, or a tapentadol-containing product.	1 year	2/14/2024
Librax (brand only)	**1.** Approve if the patient has tried BOTH a dicyclomine-containing product (tablet, capsule, syrup) AND a hyoscamine-containing product (tablet, solution). **2.** Approve if the patient has already been started on chlordiazepoxide-clidinium.	1 year	2/14/2024
lidocaine-tetracaine 7%/7% cream	Market Events does not cover this medication.	N/A	2/14/2024
Lorzone (chlorzoxazone) 375 mg tablet, generics	Market Events does not cover this medication.	N/A	2/14/2024
Lorzone (chlorzoxazone) 750 mg tablet, generics	**1.** Direct to the 500 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the chlorzoxazone 500 mg tablets. Note: If the 500 mg tablets are not currently available, approve a 1-time override.	1 year	2/14/2024
Lyrica capsules and oral solution (brand)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	2/14/2024
niacin 500 mg (generic)	Approve if the patient has tried AND cannot take at least two other prescription or over-the-counter (OTC) niacin-containing products due to a significant allergy to an inactive ingredient (e.g., dyes, fillers, etc.) or due to significant adverse reactions to the other niacin-containing products. NOTE: The physician must provide what differences in the inactive ingredient(s) which leads to an allergy to the other niacin-containing products or provide what serious adverse reactions to the other niacin-containing products that are of concern.	1 year	2/14/2024
Niacor (niacin) 500 mg tablets	Approve if the patient has tried AND cannot take at least two other prescription or over-the-counter (OTC) niacin-containing products due to a significant allergy to an inactive ingredient (e.g., dyes, fillers, etc.) or due to significant adverse reactions to the other niacin-containing products. NOTE: The physician must provide what differences in the inactive ingredient(s) which leads to an allergy to the other niacin-containing products or provide what serious adverse reactions to the other niacin-containing products that are of concern.	1 year	2/14/2024
Norgesic Forte (orphenadrine-asprin-caffeine) tablets, Orphengesic Forte (orphenadrine-asprin-caffeine) tablets, generics	Approve if the patient has tried prescription orphenadrine citrate extended-release 100 mg tablets **[documentation required]** AND an over-the-counter (OTC) aspirin and caffeine-containing product **[documentation required]**. Note: Examples of OTC aspirin and caffeine combination products include Anacin tablets, Bayer Back and Body Pain caplet, BC Arthritis powder packets.	1 year	2/14/2024
Novacort (hydrocortisone 2%/ pramoxine 1%/ aloe 1%) gel	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list: Epifoam, hydrocortisone-pramoxine cream, Pramosone cream, Pramosone lotion, or Pramosone ointment. If none are formulary, approve.	1 year	2/14/2024

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NuvaRing (brand)	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed primarily for the prevention of pregnancy AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN primarily for the prevention of pregnancy AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	2/14/2024
Osmolex (amantadine) ER tablets	Approve if the patient has tried one product from the following list: amantadine capsules, amantadine tablets, or amantadine oral solution AND meets one of the following (A or B): A. Patient derived benefit from immediate-release amantadine, but had intolerable adverse events, as determined by the prescriber; OR B. Patient could not achieve a high enough dosage to gain adequate benefit, as determined by the prescriber.	1 year	2/14/2024
oxycodone-acetaminophen 10-300 tablets (includes Primlev and Prolate tablets)	**1.** Direct to oxycodone-acetaminophen 10-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use oxycodone-acetaminophen 10-325 mg tablets.	1 year	2/14/2024
oxycodone-acetaminophen 2.5-300 tablets (includes Primlev and Prolate tablets)	**1.** Direct to oxycodone-acetaminophen 2.5-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the oxycodone-acetaminophen 2.5-325 mg tablets.	1 year	2/14/2024
oxycodone-acetaminophen 5-300 tablets (includes Primlev and Prolate tablets)	**1.** Direct to oxycodone-acetaminophen 5-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use oxycodone-acetaminophen 5-325 mg tablets.	1 year	2/14/2024
oxycodone-acetaminophen 7.5-300 tablets (includes Primlev and Prolate tablets)	**1.** Direct to oxycodone-acetaminophen 7.5-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use oxycodone-acetaminophen 7.5-325 mg tablets.	1 year	2/14/2024
Prolate (oxycodone-acetaminophen) 10-300/5 oral solution	**1.** Approve if the patient has tried and cannot take oxycodone-acetaminophen 10-325 mg tablets. **2.** Approve if the patient is unable to swallow or has difficulty swallowing tablets.	1 year	2/14/2024
Symbicort (brand)	Approve if the patient has tried one of the following: budesonide-formoterol inhalation aerosol (generic to Symbicort) or Breyna **[documentation required]**.	1 year	4/19/2024 Effective for 7/8/2024
tizandine capsules (generics)	1. Direct the patient to tizanidine tablets. 2. Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use tizanidine tablets.	1 year	2/14/2024
Treximet (sumatriptan/naproxen sodium) tablets, generics	Approve if the patient has tried naproxen AND sumatriptan tablets (Imitrex, generics). **NOTE:** A trial of the requested agent would NOT count toward meeting this requirement.	1 year	2/14/2024
Trinaz tablets (prescription dietary supplement for use throughout pregnancy).	Market Events does not cover this medication.	N/A	2/14/2024
Trudhesa Nasal Spray	Approve if the patient meets one of the following (1 or 2): **1.** Patient has tried one generic triptan nasal spray; OR Note: Examples of generic triptan nasal sprays include: sumatriptan nasal spray, zolmitriptan nasal spray. **2.** Patient has already experienced inadequate efficacy or a contraindication with a triptan product.	1 year	8/7/2024 Effective for 10/8/2024